MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

GENERAL INFORMATION

For individuals applying for a Physician's and Surgeon's Medical License or a Postgraduate Training Authorization Letter (PTAL)

Please carefully read the information on this General Information and the Application Instructions prior to beginning the process of completing the application forms and requesting all applicable supporting materials. These information sheets are designed to answer questions relative to the application process.

As an applicant, you are personally responsible for all information disclosed on your application, Forms L1A-L1E, including any responses that may have been completed on your behalf by others. An application may be denied based upon falsification or misrepresentation of any item or response on the application or any attachment.

Any alterations to any application and/or supporting application forms may result in the denial of your application. The members of the Division of Licensing consider violations of an ethical nature to be a serious breach of professional conduct.

REQUIREMENTS FOR PRINTING APPLICATION FORMS: The application forms and instructions may be downloaded to your personal computer and printed with your local printer. It is recommended that you use a high speed connection to download all forms; however, lower speed connections can download the forms. The forms require Adobe Acrobat plug-in version 5.0 or higher. It is recommended that the forms be printed using a laser jet printer. All application responses must be in the form of a " ✓" or "X". No shaded responses will be accepted.

RESOURCES AND REFERENCES: The Medical Board of California official Web site address is: www.caldocinfo.ca.gov . You may obtain application forms, general information, application instructions, applicable statutes and regulations, and contact information for other resources on the Board's Web site. You may also link directly to other state medical boards, agencies, or organizations. Please view this site for information and assistance.

GROUNDS FOR DENIAL: Each applicant's credentials for medical licensure in California are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's act of dishonesty or unprofessional conduct, conviction of a crime, discipline to another state license or inability to practice medicine safely.

PROCESSING TIMES: Application materials are processed in the date order in which the application is received in this office. To be considered an applicant, both the application, Forms L1A-L1E, and fees (or receipt indicating online payment of fees) must be received in this office. All application forms and supporting materials are stamped with the date and time received in the office. Generally, you should anticipate receiving written correspondence confirming the status of the application for medical licensure or PTAL within 90 days of submission of the application. Staff is unable to verify receipt of documents.

ACRONYMS: The following acronyms are used throughout the application forms and instructions. Most of these organizations may be reached through a link on the Medical Board of California Web site, www.caldocinfo.ca.gov.

ABMS	American Board of Medical Specialties
ACGME	Accreditation Council for Graduate Medical Education
ATA	American Translators Association
AMA	American Medical Association
DEA	Drug Enforcement Agency
DOJ	Department of Justice
DUI	Driving Under the Influence
ECFMG	Educational Commission for Foreign Medical Graduates
FBI	Federal Bureau of Investigation
FLEX	Federation Licensing Examination
FSMB	Federation of State Medical Boards
IMG	International Medical Graduate
LCME	Liaison Committee on Medical Education
LGS	Letter of Good Standing
MBC	Medical Board of California
MCC	Medical Council of Canada
NBME	National Board of Medical Examiners
PTAL	Postgraduate Training Authorization Letter
QME	Qualifying Medical Examination
RCPSC	Royal College of Physicians and Surgeons of Canada
SPEX	Special Purpose Examination
SSN	Social Security Number
U.S.	United States
USG	United States Medical Graduate
USMLE	United States Medical Licensing Examination

FEES: Application and fingerprint processing fees are non-refundable. The application processing fee of $442.00 and the fingerprint processing fee of $63.00 must accompany the initial application, Forms L1A-L1E. (If you paid application, fingerprint and/or license fees online, please attach a copy of your receipt to Forms L1A-L1E.) Failure to submit the required fees with the application, Forms L1A-L1E, will result in the delay of the processing of your application materials. The date received will be the date that fees and application Forms L1A-L1E are both received in this office. **You are only considered an applicant once processing fees and Forms L1A-E are received in this office.**

- Initial license fees of $790.00 or the reduced initial license fees of $395.00 are separate from the initial application and fingerprint processing fees. License fees may be submitted with the initial application materials. Alternatively, license fees may be submitted once the application is deemed complete.
- At the time of licensure, you may be entitled to a reduced license fee of $395.00 if you are formally appointed to a slotted position in an ACGME/RCPSC accredited postgraduate training program. A Certificate of Current Postgraduate Training Enrollment, Form L4, will be required to verify your current enrollment. The time of licensure is considered to be the date that your license number will be issued.

FINGERPRINT CLEARANCES FROM BOTH THE DOJ AND THE FBI MUST BE RECEIVED PRIOR TO THE ISSUANCE OF A PHYSICIAN'S AND SURGEON'S MEDICAL LICENSE IN CALIFORNIA.

Please be aware that if you have ever been convicted of a misdemeanor or felony, the record of conviction will be reported to the Board as a result of your fingerprint inquiry.

TWO OPTIONS ARE AVAILABLE TO OBTAIN FINGERPRINTS. PLEASE READ BELOW FOR DETAILED INFORMATION REGARDING BOTH OPTIONS.

LIVE SCAN FINGERPRINTS: Applicants who reside in California **must** complete the electronic Live Scan fingerprint process. Alternatively, applicants residing outside of California, may choose this option if visiting the state. • **CALIFORNIA DOES NOT HAVE LIVE SCAN LINKS TO ANY OTHER STATES•** You will need to contact the Board to obtain the appropriate form. On the form, please ensure that all personal data (name, AKA's, date of birth, sex, height, weight, eyes, hair, place of birth, social security number, California driver's license number and home address) is completed as required. The last section of the form requires information from the fingerprint agency; please ensure this information is completed or the forms will be void. Applicants will need to access the Web site, **http://ag.ca.gov/fingerprints/publications/contact.htm** to obtain the names and location of approved fingerprint sites. Information pertaining to the need for appointments, hours of availability and rolling fees are also available through that Web site. Applicants will need to submit the second page (Second Copy) of the three page form with the initial application, Forms L1A-L1E. The results of these fingerprints are generally received within five days. **It is the responsibility of the applicant to ensure that the person rolling the fingerprints submits TWO digital prints, one for the DOJ and one for the FBI.**

FINGERPRINTS CARDS: Applicants residing outside of California may submit hard copy fingerprint cards for processing. You will need to contact the Board to obtain the appropriate fingerprint cards. Two cards will need to be submitted: one to process through the DOJ and one to process through the FBI. On the fingerprint card, please ensure that all personal data (name, citizenship, sex, race, height, weight, eyes, hair, place of birth, date of birth, social security number, signature of person fingerprinted, date and signature of official rolling fingerprints) is completed as required. Failure to complete the required information will delay the processing of your fingerprints. The results of these fingerprint inquiries are generally received within 12 weeks.

TRANSLATIONS: All documents prepared in a language other than English must be accompanied by an original, official translation. The translation may not be prepared by an individual related to the applicant by blood, marriage or adoption. Additionally, translations may not be prepared by the applicant. To be acceptable, translations must be a literal word-for-word translation of the document; summary translations are not acceptable. Translations must be prepared on official letterhead and signed by the translator, with an attestation that the translation is accurate and complete to the best of the translator's ability. Translations may be prepared by: the medical school of graduation, a commercial translation agency, the Chairman of the Department of Foreign or Classical Languages of a major U.S. university, a consulate or U.S. Embassy, a certified or registered court interpreter, or the American Translators Association. For complete information relative to acceptable translations and translators, please refer to the "Translation of Foreign Academic Credentials."

FCVS: The Federation Credentials Verification Service (FCVS) is operated by the Federation of State Medical Boards of the United States, Inc., a national nonprofit organization that provides services for state medical and osteopathic licensing authorities in the U.S., Guam, Puerto Rico and the Virgin Islands. **The Medical Board of California does not mandate the FCVS . You will be required to complete the Board's application and provide all necessary supporting documentation.** As part of your application**,** you may request FCVS submit directly to our Board a *Physician Information Profile.* We will review the information provided along with our application and determine on an individual basis the items that we may accept from FCVS.

The application forms and Letters of Good Standing are valid for one year. After one year, they must be updated to ensure that correct and current information accurately reflects any change in an applicant's credentials.

APPLICATION UPDATE: If a medical license has not been issued one year from the date of the notarization on the application Form L1E, the application must be updated. An applicant will be required to complete and submit a **current** Initial and Update Application for Physician's and Surgeon's License or Postgraduate Training Authorization Letter, Forms L1A-L1E.

If an applicant is in need of a current PTAL, the application must be updated by completion and submission of an Initial and Update Application for Physician's and Surgeon's License or Postgraduate Training Authorization Letter, Forms L1A-LE.

LETTERS OF GOOD STANDING: A Letter of Good Standing (LGS) is considered valid for one year from the date of issuance. If a medical license has not been issued within that one year, a current LGS will be required. An applicant must request the individual authorized licensing authority to provide directly to the Board a current LGS.

ADDRESS CHANGES: All address changes must be submitted to the Board in writing. Please provide a letter that includes the date, your full name, old address, new address, current telephone number and your signature. Please note, your public/mailing address is limited to two lines with a maximum of 30 characters for each line.

DUE DILIGENCE: Pursuant to Title 16, California Code of Regulations, Section 1306, an application file that is not completed within one year is considered abandoned and may be closed. To ensure that your application file remains active, you must update your application once a year by submitting the completed Forms L1A-L1E. As a courtesy, when an application is inactive one year or more, a written notification is mailed to the last known address. If no response is received within 30 days showing progress toward completion of licensure requirements, your application will be closed and confidentially destroyed.

Listed below are the minimum required application and supporting materials required for *medical licensure for a graduate of a domestic medical school (U.S. or Canada)*. Please refer to the Application Instructions for detailed information regarding the requirements.

- Application Forms L1A-L1E
- Two fingerprint cards or copy of Live Scan form
- Fees of $505.00 or copy of receipt of online payment
- Official examination scores mailed directly from the reporting agency
- Form L2
- Official medical school transcript
- Certified copy of medical degree
- Official Letters of Good Standing (if applicable)
- Form L3A-L3B
- Form L4 (if applicable)
- License fees

Listed below are the minimum required application and supporting materials required for *medical licensure for a graduate of an international medical school*. Please refer to the Application Instructions for detailed information regarding the requirements.

- Application Forms L1A-L1E
- Two fingerprint cards or copy of Live Scan form
- Fees of $505.00 or copy of receipt of online payment
- ECFMG certificate or ECFMG Status Letter
- Official examination scores mailed directly from the reporting agency
- Form L2
- Official medical school transcript
- Certified copy of medical degree
- Official Letters of Good Standing (if applicable)
- Form L3A-L3B
- Form L4 (if applicable)
- Form L5
- Form L6 (if applicable)
- License Fees

Listed below are the minimum required application and supporting materials required for an *international medical school graduate to obtain a PTAL*. Please refer to the Application Instructions for detailed information regarding the requirements.

- Application Forms L1A-L1E
- Two fingerprint cards or copy of Live Scan form
- Fees of $505.00 or copy of receipt of online payment
- Official examination scores of USMLE Steps 1 and Step 2 (CK) mailed directly from the reporting agency
- Form L2
- Official medical school transcript
- Certified copy of medical degree
- Form L5
- Form L6 (if applicable)

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APPLICATION INSTRUCTIONS

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER, FORMS L1A-L1E

AS AN APPLICANT, YOU ARE PERSONALLY RESPONSIBLE FOR ALL INFORMATION DISCLOSED ON YOUR APPLICATION, FORMS L1A-L1E, INCLUDING ANY RESPONSES THAT MAY HAVE BEEN COMPLETED ON YOUR BEHALF BY OTHERS. AN APPLICATION MAY BE DENIED BASED UPON FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THE APPLICATION OR ANY ATTACHMENT.

ALL APPLICATION RESPONSES MUST BE IN THE FORM OF AN "X" OR "✔" MARK. NO SHADED RESPONSES WILL BE ACCEPTED.

If you are applying for licensure, check the "license" box; if you are applying for an Authorization Letter to participate in a postgraduate training program within California, check the "PTAL" box; if you currently have an open application file and are submitting the L1A-L1E to keep your file active, check the "update" box.

1. **NAME:** List current last, first and middle names as they would appear on a birth certificate, marriage certificate, and/or legal name change document. Nicknames or shortened names are not acceptable. A hyphenated last name should be provided in the same space and will be recognized by the first letter of the first name; e.g. Diaz-Jones. List all names that you have ever used; if you have changed your name, a copy of the original name change document or marriage certificate will need to be provided.

2. **SOCIAL SECURITY NUMBER:** List the number. Disclosure of your United States Social Security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c)(2)(c)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100.00 penalty against you.

3. **PLACE OF BIRTH:** List the location of your birth (i.e., city, state/province, country).

4. **DATE OF BIRTH:** List the exact date of your birth (month, day and year).

5. **GENDER:** Please check appropriate box.

6. **PUBLIC/MAILING ADDRESS:** List your public address of record as the information which will be disclosed to all persons or entities in response to a written or verbal request. **This is the address that will be posted on the internet.** The address must not be longer than thirty (30) characters per line; only two lines are available for your address. If the Public/Mailing Address is a Post Office Box, a confidential street address must be provided on a separate sheet of paper. The confidential address will not be released or utilized by the Board for mailing or notification purposes.

7. **TELEPHONE NUMBER:** List all telephone numbers including area code where you may be reached in person, or by leaving a voice mail or a message.

8. **CALIFORNIA DRIVER'S LICENSE NUMBER:** This information is optional.

9. **E-MAIL ADDRESS:** This information is optional.

10. **PREVIOUS APPLICATION:** Please check the appropriate box and provide your previous license number, if any.

11. **MEDICAL EDUCATION:** List the name of each institution attended where medical education was received. Provide the address of the institution where education was received and the dates of attendance at each institution.

- An original official medical school transcript, prepared on university letterhead affixed with the signature of the dean/registrar and the school seal, documenting all of the basic science and clinical courses completed during the medical curriculum will need to be submitted directly from the issuing institution. A transcript will need to be provided directly from each institution of attendance and submitted directly to the Board. Transcripts prepared in a language other than English will need to be accompanied by an original, official translation. Please refer to the General Instructions.

12. **DEGREE:** List the name of the school which awarded the medical degree, the degree awarded and the date the degree was issued.

- A certified copy of the medical school degree will need to be submitted directly from the medical school which issued the degree. **To be acceptable, a certified copy of the medical degree shall contain the following, and be mailed from the medical school which issued the degree directly to the Medical Board of California:**

    1. **A statement on the reverse side of the copy indicating that it is a true copy of the original degree.**
    2. **An original signature of the dean or registrar immediately following the statement verifying authenticity of the copy.**
    3. **An official medical school seal affixed to the copy.**

- Alternatively, you may submit your original medical school degree, accompanied by one 8½" x 11" photocopy. The original medical school degree will be returned by certified mail.

13. **EXAMINATIONS:** List the examination name, date of each examination, and the result of each examination (Pass/Fail). Each examination agency must submit an original official examination history report directly to the Board. Please refer to our Web site for links to examination agencies.

Please refer to our Web site at www.caldocinfo.ca.gov to obtain a copy of Section 1328 of Title 16 California Code of Regulations for a listing of all acceptable examinations. Please note that examination results of 75 or better are required to satisfy licensing requirements.

14. **ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING:** List the name and address of each program attended (internship, residency, fellowship), regardless of whether the program was completed or credit was received.

POSTGRADUATE TRAINING: If you provide an affirmative response to any of the eight (8) questions, the postgraduate training program director will need to provide a detailed narrative of the events and circumstances leading to the action(s). Copies of appropriate supplemental materials (rotation evaluations, performance evaluations, disciplinary materials, committee minute meetings, letters to file, etc.) will also need to be provided directly from the postgraduate training program. Upon receipt and review, additional required materials may be requested of the program director directly by staff.

15. **MEDICAL LICENSURE:** List the jurisdiction, license number, date of issuance and dates of practice in the jurisdiction for each license. All licenses issued by any state or territory in the United States or Canadian province will need to be reported. It is not necessary to list temporary, training, limited, or provisional licenses.

- An official *Letter of Good Standing* will need to be provided directly to the Board from each authorized licensing authority. Please note, if you are licensed in the State of Connecticut, you will need to contact them to obtain and complete a "Consent for Release of Confidential Records" as part of your request to obtain a *Letter of Good Standing*.

16. **ABMS CERTIFICATIONS:** If you are certified by a member board of the American Board of Medical Specialties, you will need to list the member board, expiration date and certificate number.

17. **MALPRACTICE HISTORY:** If you provide an affirmative response to this question, you will need to provide a detailed narrative regarding each incident of malpractice. Please provide a copy of the complaint and judgment/dismissal for each incident. A payment/claim history summary will also need to be submitted directly to the Board by each of your medical malpractice insurers. The history summary should document all claims within the preceding ten years.

QUESTIONS 18-22:

PRACTICE IMPAIRMENT OR LIMITATIONS: If you provide an affirmative response to any of these questions, you will need to provide a detailed narrative describing the events and circumstances involving the applicable issue. You will need to request that a Discharge Summary from each inpatient treatment program be submitted directly to the Board. In addition, your current treating physician or psychotherapist will need to submit directly to the Board a letter addressing your diagnosis, treatment plan, status of your impairment or limitation, and your ability to practice medicine safely. Upon receipt and review, additional materials may be requested of you or third parties.

QUESTIONS 23-25:

CRIMINAL RECORD HISTORY: These questions reference all convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution. If you provide an affirmative response to any of these questions, you will need to provide a detailed narrative describing the events and circumstances leading to the arrest and/or conviction. Certified copies of the police report, arrest report and all court documents will need to be provided directly by the issuing agency to the Board. If the records are no longer available, the court must provide a letter to that effect. If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. **Please be aware that if you have ever been convicted of a misdemeanor or felony, the record of conviction will be reported as a result of your fingerprint inquiry.**

If you provide a positive response to question 25, your application may be denied pursuant to Section 2221 of the Business and Professions Code.

QUESTIONS 26-38:

DISCIPLINARY HISTORY: If you provide an affirmative response to any of the questions, you will need to provide a detailed narrative of the events and circumstances leading to the action(s). The involved institution or agency will also need to provide a detailed summary of the events and circumstances leading to any action. Certified copies of all orders of discipline will need to be provided directly by the appropriate agency. Copies of pertinent investigatory and disciplinary documents will need to be provided to the Board directly by the appropriate authority. Upon receipt and review, additional required materials may be requested of you or third parties.

PHOTO AREA:

- One 2" x 3" photograph must be attached to the sample photo box on Form L1E. Polaroid, scanned/photcopied, and altered photographs are **not** acceptable. The photograph must be of your head and shoulder area only; the photograph must be recent.

SIGNATURE AND NOTARIZATION:

- You are **personally** responsible for all information and responses provided on the Initial and Update Application for Physician's and Surgeon's License *or* Postgraduate Training Authorization Letter, Forms L1A-L1E.

  PLEASE NOTE: Prior to initialing and signing Form L1E, please review all information and responses to ensure accuracy. As the applicant, you are personally responsible for all information disclosed on Forms L1A-L1E, including any responses that may have been completed on your behalf by others. An application may be denied based upon falsification or misrepresentation of any item or response on the application or any attachment hereto. Failure to provide responses to all questions (except 8 & 9) will require completion of a new application.

- The completed application packet (Forms L1A-L1E) must be presented to a notary. You must affix your signature and date on Form L1E in the presence of the notary, who must then affix a signature, date and seal to officially notarize your application**. To be acceptable, Forms L1A-E must be stapled together and received by the Board as one document.**

CERTIFICATE OF MEDICAL EDUCATION, FORM L2

You will need to complete the personal data (name, social security number and date of birth) at the top of the form. The form must be submitted to your medical school for completion of all information. **To certify the form, the school official must affix his/her original signature and the seal of the medical school.**

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING, FORMS L3A - L3B

Forms L3A - L3B must be completed for each year of ACGME/RCPSC postgraduate training (internship, residency, and fellowship) completed, whether or not the entire residency was completed.

You will need to complete all of the personal data (name, social security number, date of birth, telephone number, address, and medical school) in Part 1 at the top of the form. A form must be submitted to each of your ACGME/RCPSC postgraduate training program(s) for completion of all information on Form L3A - L3B. The program director must verify completion of four months of general medicine by checking the appropriate box and affixing his/her original signature on Form L3B. To certify Forms L3A - L3B, the program director must provide all of the required information and responses and affix the date, his/her original signature and the seal of the hospital. If the hospital does not have a seal, the program director's signature must be notarized. **To be acceptable, Form L3A - L3B must be stapled together and received by the Board as one document**.

CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT, FORM L4

At the time of licensure, you may be entitled to a reduced initial licensing fee if you are formally appointed to a slotted position in an ACGME/RCPSC accredited postgraduate training program.

You will need to complete the personal data (name, social security number and date of birth) at the top of the form. The form must be submitted to your program director to certify your current appointment and participation in an ACGME/RCPSC postgraduate training program position. To certify Form L4, the program director must provide all of the required information and responses and affix the date, his/her original signature and the seal of the hospital. If the hospital does not have a seal, the program director's signature must be notarized.

CERTIFICATE OF CLINICAL CLERKSHIPS, FORM L5

PLEASE NOTE: THE FORM L5 IS ONLY REQUIRED OF INTERNATIONAL MEDICAL SCHOOL GRADUATES.

You will need to complete the personal data (name, social security number, medical school and date of birth) at the top of the form. The form must be submitted to your medical school for completion of all information. **To certify the form, the school official must affix his/her original signature and the seal of the medical school.** The Form L5 must be mailed directly to the Board. You may print or copy as many L5 forms as necessary to provide a complete breakdown of your undergraduate clinical training.

For your information, the pertinent portions of Section 2089.5 of the Business and Professions Code require:

" (b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.
(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry."

Please refer to our Web site at www.caldocinfo.ca.gov to obtain a complete copy of Section 2089.5.

CERTIFICATE OF CLINICAL TRAINING, FORM L6

PLEASE NOTE: THE FORM L6 IS REQUIRED OF INTERNATIONAL MEDICAL SCHOOL GRADUATES WHO COMPLETED *ANY* CLINICAL CLERKSHIPS *OUTSIDE* OF THE PRIMARY TEACHING HOSPITAL OF THEIR MEDICAL SCHOOL.

If applicable, a Form L6 must be completed for ***each*** clinical clerkship completed *outside of the primary teaching hospital of the medical school of attendance.*

You will need to complete the personal data (name, social security number, date of birth, telephone number, address and medical school) at the top of the form in Part 1. Form L6 must be submitted to each of the hospitals where you completed clinical clerkship(s). The current program director or clinical instructor must verify completion of the clinical clerkship(s) by providing the required information and responses, and by affixing the date, his/her original signature and the hospital seal on Form L6. If the hospital does not have a seal, the program director's or clinical instructor's signature must be notarized.

For your information, only undergraduate clinical clerkships meeting the criteria specified in Section 2089.5 of the Business and Professions Code will be used to satisfy the required seventy-two (72) weeks of clinical clerkships.

Please refer to our Web site at www.caldocinfo.ca.gov to obtain a copy of Section 2089.5 of the Business and Professions Code for a listing of the required undergraduate clinical clerkships.

(Revised 12/05)

State of California Department of Consumer Affairs

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INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ❑ **License** ❑ **PTAL** **- or -** ❑ **Update**

MBC Use Only

1. NAME : Last First Middle

Other names you have used (include maiden name):

2. U.S. Social Security Number __ __ __ / __ __ / __ __ __ __

3. Place of Birth

4. Date of Birth __ __ / __ __ / __ __ __ __

5. Gender: ❑ Male ❑ Female

6. Public/Mailing Address: __
(Please note: this information is public)
(30 characters maximum per line, including spaces) __

City	State/Province	Zip/Postal Code	Country

7. Telephone Numbers: (include area code)	Home	Work	Cell

8. California Driver's License Number (optional):

9. E-mail Address (optional):

10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?
❑ Yes ❑ No
Previous license number, if any: __________________

Personal Data ❑

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance

L2 Transcript ❑ ❑ ❑ ❑ ❑ ❑

12. School of Graduation	Degree Awarded	Date of Graduation

Diploma ❑

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)

Exams ❑ ❑ ❑

Cashiering Use Only | **School Code** | **L1A**

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance	
				❑
				❑
				❑
				❑
				❑

POSTGRADUATE TRAINING: **(These questions are to be answered by ALL applicants)**

Did you ever take a leave of absence or break from your training?	YES ❑	NO ❑	❑
Have you ever been terminated, dismissed or expelled from a program?	YES ❑	NO ❑	❑
Have you ever resigned from a training program?	YES ❑	NO ❑	❑
Were you ever placed on probation?	YES ❑	NO ❑	❑
Were you ever disciplined or placed under investigation?	YES ❑	NO ❑	❑
Were any incident reports ever filed by instructors?	YES ❑	NO ❑	❑
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES ❑	NO ❑	❑
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES ❑	NO ❑	❑

MEDICAL LICENSURE

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

License Data

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	
				❑
				❑
				❑
				❑
				❑

APPLICANT: **DATE OF BIRTH:**

L1B

ABMS CERTIFICATIONS

MBC Use Only

ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties?
YES ❑ NO ❑ ❑

Member Board	Expiration Date	Certificate Number	
			❑
			❑

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more?
YES ❑ NO ❑ ❑

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES ❑ NO ❑ ❑

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES ❑ NO ❑ ❑

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES ❑ NO ❑ ❑

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES ❑ NO ❑ ❑

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES ❑ NO ❑ ❑

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES ❑ NO ❑ ❑

APPLICANT:	**DATE OF BIRTH:**	**L1C**

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only

Criminal Record

24. Is any criminal action pending against you?	YES ❑	NO ❑	❑
25. Are you required to register as a Sex Offender?	YES ❑	NO ❑	❑

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine?	YES ❑	NO ❑	❑
27. Is any denial pending against you?	YES ❑	NO ❑	❑
28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?	YES ❑	NO ❑	❑
29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	YES ❑	NO ❑	❑
30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	YES ❑	NO ❑	❑
31. Have you ever had any license to practice medicine subjected to any other disciplinary action?	YES ❑	NO ❑	❑
32. Is any disciplinary action pending against any of your licenses to practice medicine?	YES ❑	NO ❑	❑
33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	YES ❑	NO ❑	❑
34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	YES ❑	NO ❑	❑
35. Is any disciplinary action pending against your hospital staff privileges?	YES ❑	NO ❑	❑
36. Have you ever surrendered a license to practice medicine?	YES ❑	NO ❑	❑
37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	YES ❑	NO ❑	❑
38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	YES ❑	NO ❑	❑

PHOTO AREA
PASTE A 2" X 3" PHOTO HERE

PHOTO MUST BE RECENT AND MUST BE OF YOUR HEAD AND SHOULDER AREAS ONLY.

SCANNED, ALTERED, OR POLAROID PHOTOS ARE NOT ACCEPTABLE

Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, _____, _____ being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) **(DATE OF BIRTH)**
oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. ☐ **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: _____
(Please sign full name)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L1E

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that _____ ; __ __ __/__ __/__ __ __ __;
Full Name of Applicant — U.S. Social Security Number

__ __ / __ __ / __ __ __ __ ; enrolled in _____
Date of Birth — Name of Medical School

located in _____ on __ __ / __ __ / __ __ __ __.
State/Province Country — Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

Anatomy	**Embryology**	**Physical Medicine**
Otolaryngology	**Histology**	**Therapeutics**
Obstetrics and Gynecology	**Human Sexuality**	**Neuroanatomy**
Radiology, including Radiation Safety	**Medicine**	**Child Abuse Detection and Treatment**
Tropical Medicine	**Surgery, including Orthopedic Surgery**	**Geriatric Medicine**
Physiology	**Urology**	**Pediatrics**
Biochemistry	**Psychiatry**	**Pharmacology**
Pathology, Bacteriology, and Immunology	**Neurology**	**Anesthesia**
Ophthalmology	**Alcoholism and Chemical Dependency**	**Spousal Partner Abuse Detection & Treatment***
Dermatology	**Preventative Medicine, including Nutrition**	**Family Medicine****
		Pain Management and End-of-Life-Care***

*** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.**
**** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.**
***** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.**

❑ **was granted the degree of Bachelor/Doctor of Medicine on the ____ day of _____ , _____ .**

❑ **withdrew from medical school on ____ day of _____ , _____ .**

Unusual Circumstances	**Responses**	
Did this individual ever take a leave of absence from their medical education?	Yes ❑	No ❑
Was this individual ever placed on probation?	Yes ❑	No ❑
Was this individual ever disciplined or under investigation?	Yes ❑	No ❑
Were any incident reports regarding this individual ever filed by instructors?	Yes ❑	No ❑
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes ❑	No ❑

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below	**Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.**
	Signed and the school seal affixed this ____ day of _____ , _____ .
	By: _____ **Printed Name and Title of School Official**
	Signature: _____

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CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last First Middle

U.S. Social Security Number	Date of Birth	Telephone Number
___ ___ ___/ ___ ___/___ ___ ___ ___	___ ___/ ___ ___/___ ___ ___ ___	Home ( ) Work ( )

Public/Mailing Address

City State/Province Zip/Postal Code

Medical School of Graduation:

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility:

ACGME 10 digit Program number: (www.acgme.org)
___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Address of Facility:

Telephone #:

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
	___ ___/ ___ ___/___ ___ ___ ___	___ ___/ ___ ___/___ ___ ___ ___

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES ❑	NO ❑
Was the trainee ever terminated, dismissed or expelled?	YES ❑	NO ❑
Did the trainee ever resign?	YES ❑	NO ❑
Was the trainee ever placed on probation?	YES ❑	NO ❑
Was the trainee ever disciplined or placed under investigation?	YES ❑	NO ❑
Were any incident reports regarding this trainee ever filed by instructors?	YES ❑	NO ❑
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES ❑	NO ❑
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES ❑	NO ❑

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

I hereby certify as the program director, that the individual named in Part 1

❑ **has completed** ❑ **has not completed**

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

_____

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

_____

PRINT NAME OF PROGRAM DIRECTOR

_____ _____

SIGNATURE OF PROGRAM DIRECTOR **DATE SIGNED**

Signature Stamp is Not Acceptable

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

_____

SIGNATURE OF NOTARY PUBLIC

L3B

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CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last	First	Middle
U.S. Social Security Number ___ ___ ___/ ___ ___/___ ___ ___ ___	Date of Birth ___ ___/ ___ ___/___ ___ ___ ___	Medical School of Graduation:

This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on _____ **and is expected to be completed on** _____ **in** _____
Month Day Year — Month Day Year — Categorical Specialty Area of Training

at _____
Name of Facility

located at _____
Address of Facility

The 10 digit ACGME Program # : ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ (Refer to http://www.acgme.org/adspublic)

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an accredited ACGME or RCPSC postgraduate training position.

_____
PRINT NAME OF PROGRAM DIRECTOR

_____
SIGNATURE OF PROGRAM DIRECTOR – Signature Stamp Is Not Acceptable

_____ _____
DATE **TELEPHONE NUMBER**

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Hospital or Notary Seal

_____
SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

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CERTIFICATE OF CLINICAL CLERKSHIPS

(This form is only required of international medical school graduates)

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Applicant's Name: Last First Middle	U.S. Social Security Number: ___ ___ ___/___ ___/___ ___ ___ ___
Name of Medical School:	Date of Birth – MM/DD/YYYY: ___ ___/___ ___/___ ___ ___ ___

Please report undergraduate clinical clerkships in which the applicant participated in **DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING.**

MEDICAL SCHOOL CLINICAL CLERKSHIPS

Clinical Subject	Facility Name/Address	Dates of Attendance From – To (Month/Day/Year)	Weeks or Weekly Clinical Hours
		From ___ ___/___ ___/___ ___ ___ ___ To ___ ___/___ ___/___ ___ ___ ___	
		From ___ ___/___ ___/___ ___ ___ ___ To ___ ___/___ ___/___ ___ ___ ___	
		From ___ ___/___ ___/___ ___ ___ ___ To ___ ___/___ ___/___ ___ ___ ___	
		From ___ ___/___ ___/___ ___ ___ ___ To ___ ___/___ ___/___ ___ ___ ___	
		From ___ ___/___ ___/___ ___ ___ ___ To ___ ___/___ ___/___ ___ ___ ___	
		From ___ ___/___ ___/___ ___ ___ ___ To ___ ___/___ ___/___ ___ ___ ___	

Medical School Seal Must Be Imprinted Below	Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months. **Signed and the school seal affixed this _______ day of __________ , _______.** **By:** ______________________________ Printed Name and Title of School Official **Signature:** ______________________________

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CERTIFICATE OF CLINICAL TRAINING

THIS FORM IS REQUIRED FOR INTERNATIONAL MEDICAL SCHOOL GRADUATES WHO COMPLETED ANY CLINICAL TRAINING OUTSIDE OF THE PRIMARY TEACHING HOSPITAL OF THEIR MEDICAL SCHOOL.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last First Middle

U.S. Social Security Number	Date of Birth	Telephone Number
___ ___ ___/ ___ ___/ ___ ___ ___ ___	___ ___/ ___ ___/___ ___ ___ ___	Home ( ) Work ( )

Public Mailing Address

City	State/Province	Zip/Postal Code

Medical School of Graduation:

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR

_____ (Applicant Name) a student of _____ (Medical School)

completed a clerkship in _____ (Clinical Specialty) from _____ (MM/DD/YY) through _____ (MM/DD/YY)

offered by _____ (Facility Name and Mailing Address)

This facility ❑ is affiliated with a U.S., Canadian, or international medical school
Name of U.S., Canadian, or international medical school, if affiliated: _____

❑ is **not** affiliated with a U.S., Canadian, or international medical school

This facility ❑ does have an ACGME-accredited residency training program in the above clinical specialty of _____
ACGME 10 digit program number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (refer to http://www.acgme.org)

❑ does **not** have an ACGME-accredited residency training program in the above clinical specialty

I certify that I am the program director or clinical instructor and that the student named above satisfactorily completed the above named clinical clerkship and I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

PRINT NAME OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR: _____

_____
SIGNATURE OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR – Signature Stamp Is Not Acceptable

_____ _____
DATE **TELEPHONE NUMBER**

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Program Director **or clinical instructor** may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Hospital or Notary Seal

_____
SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

L6

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TRANSLATION OF FOREIGN ACADEMIC CREDENTIALS

For the Board to fairly evaluate compliance with California requirements, any applicant with non-English, foreign academic credentials must provide certified translations of those original transcripts and academic documents. These must be original, official certified translations. **Photocopies are not acceptable**. When requesting official transcripts and academic documents, an applicant whose education was completed at an institution in a bilingual country where English is one of the official languages, may be able to avoid the necessity of arranging for a translation by asking the school to generate an English language version of the transcript.

Each translator must provide an original declaration with each translation attesting to his/her fluency in the particular language and certifying under penalty of perjury that the translation is complete and accurate to the best of the translator's ability and knowledge. The Board recommends, **but does not require**, that applicants with non-English academic credentials use one of the following sources for translation:

1. **Translator accredited by the American Translators Association (ATA):** The ATA accredits individual translators by examination. Although accreditation is available only to individuals, ATA membership includes not only individuals but companies that employ accredited translators. An accredited translator must sign the translation and declaration in the presence of a Notary Public, unless the translation is a service provided by a known translation agency which affixes the document with its own official seal. ATA membership includes accredited translators residing in the U.S., Canada, Mexico, and overseas. Although the ATA does not make referrals, a listing of accredited translators and member companies is available through its Web site at www.atanet.org. The ATA may be reached by phone at 703-683-6100 or by e-mail at ata@net.org.

2. **Certified or registered court interpreter:** Some state court systems offer examinations for certification or registration of court interpreters. In California, the Judicial Council is charged with these functions. Information on court interpreters is available through the Judicial Council at 415-865-7530. General information is available via its Web site, www.courtinfo.ca.gov. The Judicial Council has contracted with Cooperative Personnel Services (CPS) for examination and certification of Certified Administrative Hearing and Medical Interpreters. A master list of these interpreters is available at the CPS Web site, www.cps.ca.gov, or telephone at 916-263-3600. The court interpreter must sign the translation and declaration in the presence of a Notary Public. Applicants residing outside California but within the United States may call the National Center for State Courts at 757-259-1517 for information on certification and registration of interpreters in other states.

Other authorized translators the Board will consider include: (1) a commercial translation agency with its own business letterhead and official agency seal or notary public seal; (2) the Chairman of the Department of Foreign or Classical Languages of a U.S. university (prepared on original school letterhead); or (3) a consulate of the U.S. Embassy with bilingual translators available.

Applicants may also request their medical school to provide original, official, literal word-for-word, certified translations of their official transcripts and academic documents. The Board will consider medical school translations prepared on the official school letterhead with the translator's original declaration, and the translator's signature and title.

ATTENTION: Translators who prepare translations **may not** be related to an applicant by blood, marriage, or adoption. Translations without an official letterhead will not be accepted.

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FEE SCHEDULE: APPLICATION FOR PHYSICIAN'S & SURGEON'S LICENSE/POSTGRADUATE TRAINING AUTHORIZATION LETTER

Date of Birth: __ __ / __ __ / __ __ __ __	**Applicant's Name:**
U.S. Social Security Number:* __ __ __ / __ __ / __ __ __ __	**Address:**

*MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS: Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(c)) authorize collection of your social security number. Your social security number will be used *exclusively for* tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

FEE CALCULATIONS:

1. ❑ Nonrefundable Application Fee: $442.00

2. ❑ Nonrefundable Fingerprint Fee: ..... $ 63.00

TOTAL REQUIRED FEES: **$505.00**

3. **VOLUNTARY** $25 FAMILY PHYSICIAN TRAINING FEE **(*please see below for information)***

❑ Please check here if you wish to contribute to the Physician Training Fund and ADD $25.00 to your payment ..... $ 25.00

You may voluntarily contribute $25.00 to provide training for family physicians and other primary care providers who will service medically underserved rural and inner city Californians, refugees, the frail elderly, and people with AIDS.

This voluntary program was established as a result of legislation authored by the late Dr. William Filante and is supported by the California Medical Association, the California Academy of Family Physicians and other leading health care organizations. Dr. Filante's bill authorized the State's Office of Statewide Health Planning and Development (OSHPD) to accept contributions from certain foundations, health maintenance organizations, health insurers, and other entities to augment these primary care training programs, which are located in hospitals throughout California.

All funds contributed will be matched with equal amounts from the University of California and the State General Fund. For more information on the Family Physician Training Program, please contact OSHPD at 1600 9th Street, Room 433, Sacramento, California 95814

4. **VOLUNTARY** $50 S.M. THOMPSON REPAYMENT PROGRAM FEE **(*please see below for information)***

❑ Please check here if you wish to contribute to the Repayment Program Fund and ADD $50.00 to your payment ..... $ 50.00

Effective January 1, 2006, physicians and surgeons and special faculty permit holders will be able to contribute $50 to the Steven M. Thompson Loan Repayment Program. This program encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their medical school loans in exchange for their service in a designated medically underserved area for a minimum of three years

TOTAL FEES ENCLOSED ..... **$_____.00**

UPON APPROVAL FOR LICENSURE, YOU WILL NEED TO SUBMIT THE INITIAL LICENSING FEE, WHICH IS IN ADDITION TO THE ABOVE FEES. You may wish to remit the initial licensing fee with the above application and fingerprint fees. The initial licensing fee is $790.00. However, if you are actively participating in an ACGME or RCPSC accredited training program at the time of licensure, you may be eligible for the reduced initial licensing fee of $395.00. To verify your current enrollment in a training program, you will need to submit a *Certificate of Current Postgraduate Training Enrollment, Form L4,* along with the $395.00 reduced initial licensing fee.

MAKE CERTIFIED CHECK, CASHIER'S CHECK OR MONEY ORDER PAYABLE TO:
MEDICAL BOARD OF CALIFORNIA
(Fees subject to change)